

Application for Section
1915(b) (4) Waiver
Fee-for-Service
Selective Contracting
Program

Application for Section 1915(b) (4) Waiver Fee-for-Service (FFS) Selective Contracting Program
Fact Sheet

The State of Maryland requests a waiver/amendment under the authority of section 1915(b) of the Act.

The Medicaid agency will directly operate the waiver. The name of the waiver program is Home and Community-Based Options (formerly known as Waiver for Older Adults).

(List each program name if the waiver authorizes more than one program.). Type of request.

This is: an initial request for new waiver. All sections are filled.

a request to amend an existing waiver, which modifies Section/Part A.

a renewal request

Section A is: replaced in full carried over with no changes changes noted in BOLD.

Section B is: replaced in full changes noted in BOLD.

Effective Dates: This waiver renewal is requested for the period of 7/1/2021 to 6/30/2026.

State Contact: The State contact person for this waiver is Kesha Shaw and can be reached by telephone at (410) 767-1483 or e-mail at Kesha.Shaw@maryland.gov.

Part I: Program Overview

Tribal Consultation:

Describe the efforts the State has made to ensure that Federally-recognized tribes in the State are aware of and have had the opportunity to comment on this waiver proposal.

In accordance with Section 1902(a)(73) of the Social Security Act, Maryland Medicaid seeks advice on a regular, ongoing basis from designees including Maryland's Urban Indian Organization. In November, 2010, the State appointed a designee of the Urban Indian Organization to the Maryland Medicaid Advisory Committee (MMAC). The MMAC meets monthly and receives updates on demonstration projects, pertinent policy issues, waivers, regulations and State Plan Amendments (SPAs) for all Medicaid Programs. These communications occur prior to the submission of waivers, amendments and other policy changes. Maryland also consults with the Urban Indian Organization (UIO) on an as needed basis to develop SPAs and regulations which will have a direct impact on access to health care systems as well as the provision of care/services for Indian populations.

On April ~~29, 2021 and May 7, 2021~~ ~~8th 2016~~, The State contacted the Urban Indian Organization about this renewal amendment.

The UIO responded on ~~XXXX~~ ~~that day that they had no comments.~~

Program Description:

Provide a brief description of the proposed selective contracting program or, if this is a request to amend an existing selective contracting waiver, the history of and changes requested to the existing program. Please include the estimated number of enrollees served throughout the waiver.

The waiver requested is limited to the case management services in the existing 1915(c) waiver, Home and Community-Based Options.

This waiver provides services, including case management to adults ages 18 and over who meet nursing facility level of care. Under the 1915(b)(4) authority, the State currently waives the freedom of choice of providers for case management services offered under the 1915(c) authority. The Area Agencies on Aging (AAAs) will continue to be the designated

Providers. Maryland will continue to utilize the ~~and~~ competitive solicitation process ~~will continue~~ to identify one or more providers per region to offer a limited choice of providers to the participants within each region.

Waiver Services:

Please list all existing State Plan services the State will provide through this selective contracting waiver.

Waiver case management services.

A. Statutory Authority

1. Waiver Authority. The State seeks authority under the following subsection of 1915(b):

X 1915(b) (4) - FFS Selective Contracting program

2. Sections Waived. The State requests a waiver of these sections of 1902 of the Social

Security Act:

a. ___ Section 1902(a) (1) - Statewideness

b. ___ Section 1902(a) (10) (B) - Comparability of Services

c. **X** ___ Section 1902(a) (23) - Freedom of Choice

d. ___ Other Sections of 1902 – (please specify)

B. Delivery Systems

1. Reimbursement. Payment for the selective contracting program is:

___ the same as stipulated in the State Plan

X ___ is different than stipulated in the State Plan (please describe)

In accordance with COMAR 10.09.54.22, a fee schedule shall be published at least annually by the Department, and the rates are increased on July 1 of each year, subject to the limitations of the State budget, by the lesser of ~~32.5~~32.5% or the percentage of the annual increase in the March Consumer Price Index for All Urban Consumers, all items component, Washington-Baltimore, from the U.S. Department of Labor, Bureau of Labor Statistics. The Office of Long Term Services and Supports~~Health~~ implements rate adjustments in accordance with these regulatory provisions.

2. Procurement. The State will select the contractor in the following manner:

___ Competitive procurement

___ Open cooperative procurement

___ Sole source procurement

X Other (please describe)

The State of Maryland ~~will designate up to case management providers include all of the Area Agencies on Aging (AAAs) in the State. (the total number of AAAs in the state) as case management providers. The State -utilizes and will also use a competitive solicitation process to identify additional providers, as needed. Since the rates are -will be set in regulation, the proposals are will be evaluated solely on quality and experience.~~

County										
Allegany County, Maryland	Area Agencies on Aging (AAA)	Medical Management and Rehabilitations Services (MMARS)	The Coordinating Center (TCC)	Total Care Sevices (TCS)	Beatrice Loving Heart (BLH)	Service Coordination Inc. (SCI)				
Anne Arundel County, Maryland	Area Agencies on Aging (AAA)	Medical Management and Rehabilitations Services (MMARS)	The Coordinating Center (TCC)	Total Care Sevices (TCS)	Beatrice Loving Heart (BLH)	Service Coordination Inc. (SCI)		Southern Maryland Center for Independent Living (SMCIL)		
Baltimore, Maryland	Area Agencies on Aging (AAA)	Medical Management and Rehabilitations Services (MMARS)	The Coordinating Center (TCC)	Total Care Sevices (TCS)	Beatrice Loving Heart (BLH)	Service Coordination Inc. (SCI)			WJ Community Integration Services, LLC (WJCIS)	
Baltimore County, Maryland	Area Agencies on Aging (AAA)	Medical Management and Rehabilitations Services (MMARS)	The Coordinating Center (TCC)	Total Care Sevices (TCS)	Beatrice Loving Heart (BLH)	Service Coordination Inc. (SCI)			WJ Community Integration Services, LLC (WJCIS)	
Calvert County, Maryland	Area Agencies on Aging (AAA)	Medical Management and Rehabilitations Services (MMARS)	The Coordinating Center (TCC)	Total Care Sevices (TCS)	Beatrice Loving Heart (BLH)	Service Coordination Inc. (SCI)		Southern Maryland Center for Independent Living (SMCIL)		
Caroline County, Maryland	Area Agencies on Aging (AAA)	Medical Management and Rehabilitations Services (MMARS)	The Coordinating Center (TCC)	Total Care Sevices (TCS)			Bay Area Center for Independent Living (BACIL)			
Carroll County, Maryland	Area Agencies on Aging (AAA)	Medical Management and Rehabilitations Services (MMARS)	The Coordinating Center (TCC)	Total Care Sevices (TCS)	Beatrice Loving Heart (BLH)	Service Coordination Inc. (SCI)				
Cecil County, Maryland	Area Agencies on Aging (AAA)	Medical Management and Rehabilitations Services (MMARS)	The Coordinating Center (TCC)	Total Care Sevices (TCS)			Bay Area Center for Independent Living (BACIL)			
Charles County, Maryland	Area Agencies on Aging (AAA)	Medical Management and Rehabilitations Services (MMARS)	The Coordinating Center (TCC)	Total Care Sevices (TCS)	Beatrice Loving Heart (BLH)	Service Coordination Inc. (SCI)		Southern Maryland Center for Independent Living (SMCIL)		
Dorchester County, Maryland	Area Agencies on Aging (AAA)	Medical Management and Rehabilitations Services (MMARS)	The Coordinating Center (TCC)	Total Care Sevices (TCS)			Bay Area Center for Independent Living (BACIL)			
Frederick County, Maryland	Area Agencies on Aging (AAA)	Medical Management and Rehabilitations Services (MMARS)	The Coordinating Center (TCC)	Total Care Sevices (TCS)	Beatrice Loving Heart (BLH)	Service Coordination Inc. (SCI)				
Garrett County, Maryland	Area Agencies on Aging (AAA)	Medical Management and Rehabilitations Services (MMARS)	The Coordinating Center (TCC)	Total Care Sevices (TCS)	Beatrice Loving Heart (BLH)	Service Coordination Inc. (SCI)				
Harford County, Maryland	Area Agencies on Aging (AAA)	Medical Management and Rehabilitations Services (MMARS)	The Coordinating Center (TCC)	Total Care Sevices (TCS)	Beatrice Loving Heart (BLH)	Service Coordination Inc. (SCI)				
Howard County, Maryland	Area Agencies on Aging (AAA)	Medical Management and Rehabilitations Services (MMARS)	The Coordinating Center (TCC)	Total Care Sevices (TCS)	Beatrice Loving Heart (BLH)	Service Coordination Inc. (SCI)				
Kent County, Maryland	Area Agencies on Aging (AAA)	Medical Management and Rehabilitations Services (MMARS)	The Coordinating Center (TCC)	Total Care Sevices (TCS)			Bay Area Center for Independent Living (BACIL)			
Montgomery County, Maryland	Area Agencies on Aging (AAA)	Medical Management and Rehabilitations Services (MMARS)	The Coordinating Center (TCC)	Total Care Sevices (TCS)	Beatrice Loving Heart (BLH)	Service Coordination Inc. (SCI)			WJ Community Integration Services, LLC (WJCIS)	Independence Now (IN)

County										
Prince George's County, Maryland	Area Agencies on Aging (AAA)	Medical Management and Rehabilitations Services (MMARS)	The Coordinating Center (TCC)	Total Care Sevices (TCS)	Beatrice Loving Heart (BLH)	Service Coordination Inc. (SCI)		Southern Maryland Center for Independent Living (SMCIL)	WJ Community Integration Services, LLC (WJCIS)	
Queen Anne's County, Maryland	Area Agencies on Aging (AAA)	Medical Management and Rehabilitations Services (MMARS)	The Coordinating Center (TCC)	Total Care Sevices (TCS)			Bay Area Center for Independent Living (BACIL)			
Somerset County, Maryland	Area Agencies on Aging (AAA)	Medical Management and Rehabilitations Services (MMARS)	The Coordinating Center (TCC)	Total Care Sevices (TCS)			Bay Area Center for Independent Living (BACIL)			
St. Mary's County, Maryland	Area Agencies on Aging (AAA)	Medical Management and Rehabilitations Services (MMARS)	The Coordinating Center (TCC)	Total Care Sevices (TCS)	Beatrice Loving Heart (BLH)	Service Coordination Inc. (SCI)		Southern Maryland Center for Independent Living (SMCIL)		
Talbot County, Maryland	Area Agencies on Aging (AAA)	Medical Management and Rehabilitations Services (MMARS)	The Coordinating Center (TCC)	Total Care Sevices (TCS)			Bay Area Center for Independent Living (BACIL)			
Washington County, Maryland	Area Agencies on Aging (AAA)	Medical Management and Rehabilitations Services (MMARS)	The Coordinating Center (TCC)	Total Care Sevices (TCS)	Beatrice Loving Heart (BLH)	Service Coordination Inc. (SCI)				
Wicomico County, Maryland	Area Agencies on Aging (AAA)	Medical Management and Rehabilitations Services (MMARS)	The Coordinating Center (TCC)	Total Care Sevices (TCS)			Bay Area Center for Independent Living (BACIL)			
Worcester County, Maryland	Area Agencies on Aging (AAA)	Medical Management and Rehabilitations Services (MMARS)	The Coordinating Center (TCC)	Total Care Sevices (TCS)			Bay Area Center for Independent Living (BACIL)			

Allegany County	Area Agencies on Aging (AAA)	Beatrice Loving Heart Agency	Medical Management and Rehabilitation Services (MMARS)	The Coordinating Center (TCC)	
Anne Arundel County	Area Agencies on Aging (AAA)	Beatrice Loving Heart Agency	Medical Management and Rehabilitation Services (MMARS)	The Coordinating Center (TCC)	
Baltimore County	Area Agencies on Aging (AAA)	Beatrice Loving Heart Agency	Medical Management and Rehabilitation Services (MMARS)	The Coordinating Center (TCC)	
Baltimore City	Area Agencies on Aging (AAA)	Beatrice Loving Heart Agency	Medical Management and Rehabilitation Services (MMARS)	The Coordinating Center (TCC)	
Calvert County	Area Agencies on Aging (AAA)	Beatrice Loving Heart Agency	Medical Management and Rehabilitation Services (MMARS)	The Coordinating Center (TCC)	
Caroline County	Area Agencies on Aging (AAA)	Bay Area Center for Independent Living (BACIL)	Medical Management and Rehabilitation Services (MMARS)	The Coordinating Center (TCC)	
Carroll County	Area Agencies on Aging (AAA)	Beatrice Loving Heart Agency	Medical Management and Rehabilitation Services (MMARS)	The Coordinating Center (TCC)	
Cecil County	Area Agencies on Aging (AAA)	Bay Area Center for Independent Living (BACIL)	Medical Management and Rehabilitation Services (MMARS)	The Coordinating Center (TCC)	
Charles County	Area Agencies on Aging (AAA)	Beatrice Loving Heart Agency	Medical Management and Rehabilitation Services (MMARS)	The Coordinating Center (TCC)	
Dorchester County	Area Agencies on Aging (AAA)	Bay Area Center for Independent Living (BACIL)	Medical Management and Rehabilitation Services (MMARS)	The Coordinating Center (TCC)	
Fredrick County	Area Agencies on Aging (AAA)	Beatrice Loving Heart Agency	Medical Management and Rehabilitation Services (MMARS)	The Coordinating Center (TCC)	
Garrett County	Area Agencies on Aging (AAA)	Beatrice Loving Heart Agency	Medical Management and Rehabilitation Services (MMARS)	The Coordinating Center (TCC)	
Harford County	Area Agencies on Aging (AAA)	Beatrice Loving Heart Agency	Medical Management and Rehabilitation Services (MMARS)	The Coordinating Center (TCC)	
Howard County	Area Agencies on Aging (AAA)	Beatrice Loving Heart Agency	Medical Management and Rehabilitation Services (MMARS)	The Coordinating Center (TCC)	
Kent County	Area Agencies on Aging (AAA)	Bay Area Center for Independent Living (BACIL)	Medical Management and Rehabilitation Services (MMARS)	The Coordinating Center (TCC)	
Montgomery County	Area Agencies on Aging (AAA)	Beatrice Loving Heart Agency	Medical Management and Rehabilitation Services (MMARS)	The Coordinating Center (TCC)	Independence Now

Prince George's County	Area Agencies on Aging (AAA)	Beatrice Loving Heart Agency	Medical Management and Rehabilitation Services (MMARS)	The Coordinating Center (TCC)	
Queen Anne's County	Area Agencies on Aging (AAA)	Bay Area Center for Independent Living (BACIL)	Medical Management and Rehabilitation Services (MMARS)	The Coordinating Center (TCC)	
St. Mary's County	Area Agencies on Aging (AAA)	Beatrice Loving Heart Agency	Medical Management and Rehabilitation Services (MMARS)	The Coordinating Center (TCC)	
Somerset County	Area Agencies on Aging (AAA)	Bay Area Center for Independent Living (BACIL)	Medical Management and Rehabilitation Services (MMARS)	The Coordinating Center (TCC)	
Talbot County	Area Agencies on Aging (AAA)	Beatrice Loving Heart Agency	Medical Management and Rehabilitation Services (MMARS)	The Coordinating Center (TCC)	
Washington County	Area Agencies on Aging (AAA)	Beatrice Loving Heart Agency	Medical Management and Rehabilitation Services (MMARS)	The Coordinating Center (TCC)	
Wicomico County	Area Agencies on Aging (AAA)	Bay Area Center for Independent Living (BACIL)	Medical Management and Rehabilitation Services (MMARS)	The Coordinating Center (TCC)	
Worcester County	Area Agencies on Aging (AAA)	Bay Area Center for Independent Living (BACIL)	Medical Management and Rehabilitation Services (MMARS)	The Coordinating Center (TCC)	

C. Restriction of Freedom of Choice

1. Provider Limitations.

Beneficiaries will be limited to a single provider in their service area.

Beneficiaries will be given a choice of providers in their service area.

The State intends to have at least two providers per county. Supports Planning Agencies (SPAs) are identified through a competitive solicitation process. There is one AAA [in every county that serves every county.](#)

Montgomery County has [74](#) other SPAs; all other counties have [3-4](#) other SPAs.

2. State Standards.

Detail any difference between the state standards that will be applied under this waiver and those detailed in the State Plan coverage or reimbursement documents.

~~There are no differences between the state standards and those applied under the [waiver/waiver.](#)~~

~~Two providers per county is the minimum but not the norm. We strive for, and have provided, more options. A minimum of two providers ensure choice of provider and adequate coverage. Agencies have more staff in more populated areas of the state.~~

D. Populations Affected by Waiver

(May be modified as needed to fit the State's specific circumstances)

1. Included Populations. The following populations are included in the waiver:

- Section 1931 Children and Related Populations
- Section 1931 Adults and Related Populations
- Blind/Disabled Adults and Related Populations
- Blind/Disabled Children and Related Populations
- Aged and Related Populations
- Foster Care Children
- Title XXI CHIP Children

2. Excluded Populations. Indicate if any of the following populations are excluded from participating in the waiver:

- Dual Eligibles
- Poverty Level Pregnant Women
- Individuals with other insurance
- Individuals residing in a nursing facility or ICF/MR
- Individuals enrolled in a managed care program
- Individuals participating in a HCBS Waiver program
- American Indians/Alaskan Natives
- Special Needs Children (State Defined). Please provide this definition.
- Individuals receiving retroactive eligibility

Other (Please define): The population covered for this waiver is limited to applicants and enrollees of the 1915(c) Home and Community-Based Options Waiver.

Part II: Access, Provider Capacity and Utilization Standards

A. Timely Access Standards

Describe the standard that the State will adopt (or if this is a renewal or amendment of an existing selective contracting waiver, provide evidence that the State has adopted) defining timely Medicaid beneficiary access to the contracted services, i.e., what constitutes timely access to the service?

1. How does the State measure (or propose to measure) the timeliness of Medicaid beneficiary access to the services covered under the selective contracting program?

All Supports Planning Agencies are required to sign a provider agreement and adhere to the Provider Solicitation (Comprehensive Case Management and Supports Planning Services for Medicaid Long-Term Services and Supports). Timely access for case management is defined in the Supports Planning Solicitation, Section 3.5 Freedom of Choice section and Section 3.5 Supports Planning. Case management agencies must establish contact and perform an initial visit with the referred applicant or participant within 14 calendar days of receipt of the referral. Additionally, Section 3.5.26 indicates unless waived, the case manager must meet with the participant in-person, or if directed by the Department, virtually, at the location where he or she receives services at least every 90 days.

Upon application for services, the Department will provide a packet of materials that includes brochures from all eligible case management and supports planning providers available in the applicant's area. Applicants are encouraged to contact case management and supports planning providers prior to selection. The applicant may choose a provider by contacting the Department or the chosen provider directly. This choice will be noted in LTSSMaryland. Applicants and participants who do not choose a provider within 21 days of receipt of the provider information packet will be auto assigned to a provider via LTSSMaryland to assure equal distribution of auto assignments among eligible providers. The applicant or participant will be able to change the auto-assigned provider at any time; however, once a provider is chosen by the participant, the 45-day limitation described below will apply.

Applicants and participants may choose to change their provider as needed, but no more than once every 45 calendar days. Once an applicant or participant chooses a new provider, the current provider will have 14 calendar days to complete their work with the applicant/participant. The new provider will receive 14 calendar days notice and then become responsible for the provision of services on day 15. An applicant or participant may only request a change of provider after 45 calendar days with their current provider to ensure adequate transition time and continuity of services. For example, if a participant who is already working with a supports planning provider chooses a new provider on January 1st, the change would be effective on January 15th. The participant is not eligible to request another change in provider until March 1.

The provider will monitor annual redetermination dates, meet with the waiver participant to complete financial redetermination paperwork and facilitate the gathering of required documentation for the redetermination based on the requirements and timelines set forth in the provider solicitation.
will be defined in the procurement documents

~~and provider agreements. The State uses a web-based LTSS tracking system to monitor programs and it will use this system to monitor service provision of the covered services.~~

~~Individuals who are referred to the Community First Choice program are provided information brochures about all the supports planning agencies that serve their geographic area. Participants are encouraged to call the provider of their choice to select them and get access to services. If participants do not contact an agency to select them directly, the system will assign the individual to a provider on 21st day. This system check ensures all participants are assigned to a~~

~~supports planning agency.~~

~~All Supports Planning Agencies are required to sign a provider agreement and adhere to the Provider Solicitation (Comprehensive Case Management and Supports Planning Services for Medicaid Long Term Services and Supports). Section 3.4 of the Provider Solicitation outlines services for applicants and specifies contact should be made with the participant within 14 calendar days of assignment to their agency. Section 3.6 of the Provider Solicitation requires supports planners to make direct contact with participants as needed and at minimum every 30 days with a quarterly home visit every 90 days.~~

2. Describe the remedies the State has or will put in place in the event that Medicaid beneficiaries are unable to access the contracted service in a timely fashion.

~~The State will require a corrective action plan (CAP) for a provider that fails to meet timely access standards. The CAP will entail the allegation and supporting documentation.~~

~~Providers are responsible to ensure compliance with all performance measures included in the Department's waiver applications through the development of a Quality Assurance (QA) and Quality Improvement (QI) Plan. The provider must develop and implement a QI/QA plan, to be approved by the Department, to evaluate to ensure compliance with all responsibilities and their associated timeframes contained in the Provider Solicitation. Providers must review their QI/QA plans at least annually to evaluate its effectiveness in achieving the requirements noted in the Provider Solicitation and incorporate into the plan any additional performance measures requested by the Department as part of its comprehensive quality program. Develop a quality assurance plan. The State will require implement a corrective action plan (CAP) for a provider that fails to meet timely access standards. The CAP will entail the allegations and supporting documentation.~~

~~access standards. The CAP will entail the allegation and supporting documentation.~~

~~The will evaluate and monitor the corrective action progression the provider demonstrates the understanding to meet the standards set forth by the Department. In the event the providers fail to meet timely access standards~~

~~under the CAP, the State will take action based on the following procurement rules:~~

~~During the current waiver period, 12-5 Corrective Action Plans (CAP) were issued for delays in supports planning agencies submitting plans of services services. No CAPs were issued for delays in assigning a supports planner.~~

All agencies were required to submit the following in response to the
the plan of service timeliness CAP:

1. Description of the quality assurance plan in place to identify delays in timely services,

including names of staff responsible for implementing the plan;

~~2. A list of all active applicants and participants that includes the date of the assessment, the date the plan of service (POS) was submitted to the Department, and a calculation of the days to submission of the POS.~~

~~3. A calculation of the average days to POS submission across the agency and per individual supports planner;~~

~~4. The total number of plans currently overdue with the days each plan is overdue;~~

~~2.5.~~ Description of the remediation process in place to address these delays;

~~3.6.~~ Training materials for staff that include time frames and the quality assurance process;

~~74.~~ An indication of what has been done to address this matter; and

~~5. 8.~~ An action plan that will be put in place to prevent a reoccurrence of this situation.

All CAP responses are reviewed and approved at Department. All SPA agencies have assigned liaison from the Department who provides technical assistance and monitors adherence to established quality plans.

The Department will implement a remediation plan including review of the QI/QA plan, training materials, case consultations, business processes, and other pertinent factors that would may need to be addressed.

The Department will evaluate and monitor the corrective action progress on an ongoing basis until the provider demonstrates the understanding to meet the standards set forth by the Department.

A. Provider Capacity Standards

Describe how the State will ensure (or if this is a renewal or amendment of an existing selective contracting waiver, provide evidence that the State has ensured) that its selective contracting program provides a sufficient supply of contracted providers to meet Medicaid beneficiaries' needs.

1. Provide a detailed capacity analysis of the number of providers (e.g., by type, or number of beds for facility-based programs), or vehicles (by type, per contractor for non-emergency transportation programs), needed per location or region to assure sufficient capacity under the selective contracting program.

The State requires any AAA that chooses to provide supports planning to establish a maximum number of people they are able to serve. Based on these projected numbers, the State ~~will solicit~~ case management providers and will award ~~based onto ensure~~ sufficient capacity to serve all enrollees and applicants. The max ratio of enrollees and applicants to supports planners is 55:1. In the event that a provider exceeds/reaches capacity, their capacity will be reviewed and the client may be referred to another agency, or may be placed on a waitlist until such time an agency has capacity to provide the service. If an individual is placed on a waitlist, all agency capacity is reviewed monthly by the Department to ensure timeliness of services.

The State monitors agency capacity and ~~has will~~ re-solicit~~ed~~ providers as needed. The State ~~has~~ also work~~ed~~ with existing agencies to increase capacity as needed within the system, and target~~ed~~ by region as needed.

2. Describe how the State will evaluate and ensure on an ongoing basis that providers are appropriately distributed throughout the geographic regions covered by the selective contracting program so that Medicaid beneficiaries have sufficient and timely access throughout the regions affected by the program.

There are always a minimum of at least two case management agencies within a jurisdiction. The term of the current Supports Planning agreement is April 1, 2021 through December 31, 2021 with three annual option periods as indicated below:

1. January 1, 2022 to December 31, 2022
2. January 1, 2023 to December 31, 2023
3. January 1, 2024 to December 31, 2024

The State monitors case management capacity per region/jurisdiction at minimum on a semi-annual basis via the SPA Capacity Report in LTSSMaryland. This report allows the State to evaluate applicant/enrollee distribution versus maximal allowable case management agency capacity. This information assists the State with projecting regions/jurisdictions that may encounter insufficient case management services. The one year terms in the provider solicitation process allows the State to issues an amendment to solicit for additional case management providers, if needed. The Department will also allow existing providers who have no pending CAPS to expand their capacity to meet additional needs in the event of insufficient capacity.

~~In solicitation In order to allow flexibility, the State enrolls case management providers in yearly agreements. The State will review on an bi-annual basis the distribution of enrollees and applicants and may solicit additional will revise the number of providers accordingly if needed. The State monitors provider capacity monthly and may solicit additional providers more frequently if~~

needed.

Reports in web-based tracking system, LTSS, are monitored regularly including a “SPA – Capacity report”. There are always a minimum of two provider agencies per region.

B. Utilization Standards

Describe the State’s utilization standards specific to the selective contracting program.

1. How will the State (or if this is a renewal or amendment of an existing selective contracting waiver, provide evidence that the State) regularly monitor(s) the selective contracting program to determine appropriate Medicaid beneficiary utilization, as defined by the utilization standard described above?

To ensure appropriate utilization of services, agencies are required to set standards, for Department review through the development and implementation of a Quality Improvement/Quality Assurance plan. This plan is to evaluated and submitted to the state to review the effectiveness in achieving the requirements noted in in the Provider Solicitation, as well as incorporate any additional performance measures requested by the Department. Additionally, the service needs of the applicant/enrollee are documented in the annual redetermination and the person-centered plan. The Department reviews the Plan of Service, assessment, and Reportable Event forms to determine if the plan meets the needs of the participant. The Department also evaluates the utilization of services during agency annual on-site audits, as well as through weekly billing audits, and regular data reviews with the use of reports in LTSSMaryland to ensure the provision of services meets Department standards for utilization and identify deficiencies.

Additionally participant’s have case management units identified on their person-centered plan of service (POS) that is reviewed and approved or denied by the Department in LTSSMaryland. The State monitors the number of case management units utilized/billed versus the number of case management units on their POS via reports in LTSSMaryland to monitor case management utilization.

The State uses XXXX reports in LTSSMaryland to monitor case management Activities (units of case management services) versus the number of case management units on a participant’s approved plan of service.

The State uses XXXX reports in LTSSMaryland to monitor case management Activities (units of case management services) versus the number of case management units on a participant’s approved plan of service.

The Department also conducts a weekly billing audit of case management Activiites to ensure they CMA is not exceeding the number of allowable units.

As outlined in the provider solicitation annual audit to monitor quality of services.

Supports Planning Agencies also

The State maintains a case management module through the LTSS tracking system that monitors the number of case management units approved on the plan of service and billed by each provider. Reports from this system will be used to by the State to monitor service utilization.

The State reviews supports planning billing quarterly using reports from the LTSS tracking system.

The State reviews transition services billing continuously, with reports from the contractor on minimum of a monthly basis. Currently the State review all transition fund claims.

2. Describe the remedies the State has or will put in place in the event that Medicaid beneficiary utilization falls below the utilization standards described above.

~~If Agencies are failing to meet the needs of clients, as well as the provider requirements set forth in the Provider Solicitation, The Department will issues a CAPs to against any provider agency that falls below the beneficiary utilization standards outlined in the above, in the provider solicitation, or is noncompliant with Department regulations and policies. failing to follow department standards and regulations. CAP and Monthly quality improvement pain until they can demonstrate the standards that are outlined in the solicitation. All SPA that do not have CAPS to expand to meet needs.~~

~~Participants have case management units identified on their person-centered and Department-approved Plan of Service which is maintained in the LTSS tracking system. The number of case management units utilized is monitored via reports in the LTSS tracking system. The State monitors the total number of applicants and participants to be served against the capacity of current agencies, taking into account predetermined caseload ratios and enrollment trends. If and when the maximum capacity of current providers is expected to be reached within the next 6 months, the State will solicit additional providers. The State will also allow existing providers who have no pending CAPs to expand their capacity to meet additional need. Based on a review of claims, there was no indication of utilization below the standard.~~

Part III: Quality

A. Quality Standards and Contract Monitoring

1. Describe the State's quality measurement standards specific to the selective contracting program.

a. Describe how the State will (or if this is a renewal or amendment of an existing selective contracting waiver, provide evidence that the State):

i. Regularly monitor(s) the contracted providers to determine compliance with the State's quality standards for the selective contracting program.

Quality requirements and remediation activities will be defined in the competitive solicitation process for case management.

~~Reportable Event process and annual audit based on quality from solicitation.~~

~~Agencies must demonstrate the quality of supports planning services provided through an annual evaluation of their effectiveness in achieving the requirements by way of their QI/QA plan. This plan must indicate how data will be collected through evaluation activities to achieve full compliance with all requirements of the Provider Solicitation. Each SPA agency is provided technical assistance and assisted to help identify issues that needed remediation (not complaint with the Solicitation).~~

~~Additionally, agency performance is reviewed through comprehensive client record reviews and an annual on-site and desk audit. reviews.~~

~~The Department also reviews assessment outcomes on new applicants to verify level of care and authorize the Plan of Service. Additionally, the Department manages the waiver expenditures against the approved levels of care by comparing the information with paid claims data reports.~~

~~The State will require a corrective action plan and implement a remediation plan for an provider agency that fails to meet~~

~~quality the quality standards. In the event the providers fail to meet standards under the~~

~~remediation plan CAP, the State will take action to terminate the designation as a case management~~

~~provider and transition all participants to other providers identified through the~~

~~competitive solicitation process.~~

~~The state also has a reportable events policy that is used to follow-up on significant~~

~~incidents and complaints for the Home and Community-Based Options waiver as~~

~~well as State Plan Community First Choice and Community Personal Assistance~~

~~Services programs. Once a complaint is received by the State, staff the eD department will review the~~

~~findings and supporting documentation, follow-up with appropriate~~

~~entities/parties, and if necessary, determine and implement appropriate action~~

~~involving the participant, provider, etc., such as recommending a Corrective Action Plan (CAP). The policy in its entirety may be found at;~~

~~<https://mmcp.dhmh.maryland.gov/docs/RE-POLICY-FINAL-VERSIONOHS.pdf>~~

~~Providers are required to meet certain case management standards and are monitored with regards to their performance in the matters of participant safeguards in the quality improvement-health and welfare section of the 1915(c) application. Performance measures are outlined in the provider solicitation and agreement monitored on a quarterly basis by the State.~~

~~The State has one reportable events policy that is used to follow-up on significant incidents and complaints for the Home and Community-Based Options waiver as well as State Plan Community First Choice and Community Personal Assistance Services programs. All providers are required to comply with the reportable events policy. Once a complaint is received by the State, staff will review the findings and supporting documentation, follow up with appropriate entities/parties, and if necessary, determine and implement appropriate action involving the participant, provider, etc., such as recommending a Corrective Action Plan (CAP). The policy in its entirety may be found at;~~

~~<https://mmcp.dhmh.maryland.gov/docs/RE-POLICY-FINAL-VERSIONOHS.pdf>~~

~~Providers are required to meet certain case management standards and are monitored with regards to their performance in the matters of participant safeguards in the quality improvement health and welfare section of the 1915(c) application. Performance measures are outlined in the provider solicitation and agreement monitored on a quarterly basis by the State.~~

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~~The State or designee conducts at least an annual review of each case management agency. N: Total number of case management oversight reviews completed annually. D: Total number of approved case management agencies. Unlicensed providers of case management will be sent a letter of minimum~~

~~qualifications they must meet. PM — Number of unlicensed case management providers who meet minimum qualifications for providing services annually. N: Number of unlicensed case management providers that meet waiver requirements. D: Number of unlicensed providers who billed for the year.~~

~~Each SPA agency had an assigned liaison to provide technical assistance and identify issues that needed remediation (not complaint with the Solicitation).~~

~~ii. Take(s) corrective action if there is a failure to comply.~~

~~The State will require a corrective action plan for a provider that fails to meet quality standards. In the event the providers fail to meet standards under the CAP, the State will take action to terminate the designation as a case management provider and transition all participants to other providers identified through the competitive solicitation process.~~

~~37 Corrective Action Plans (CAPs) were issued, and all 37 required written response and identification of an immediate plan for remediation and ongoing quality assurance plan to ensure adherence to the provider solicitation.~~

2. Describe the State's contract monitoring process specific to the selective contracting program.

a. Describe how the State will (or if this is a renewal or amendment of an existing selective contracting waiver, provide evidence that the State):

i. Regularly monitor(s) the contracted providers to determine compliance with the contractual requirements of the selective contracting program.

[By submitting a proposal for the Provider Solicitation, the provider agrees to comply with all requirements noted in the Solicitation, as well as those noted in the Medicaid Provider Agreement. The provider also agrees to comply with all applicable regulations, specifically COMAR 10.09.20, 36, 54, 81 and 84 and all applicable Community Personal Assistance Services, Community First Choice, Home and Community Based Options Waiver, and Increased Community Services program policies. The Department may terminate the agreement at any time by notifying the provider in writing. The provider will submit a transition plan that clearly describes how applicants/enrollees will be assisted regarding the selection of a new provider, transition of files and other data in a Health Insurance Portability and Accountability Act of 1996 \(HIPAA\)-compliant manner and the reason for termination.](#)

[The Department reviews agency data, caseload and activities maintained in LTSSMaryland on a quarterly regular basis to identify trends or issues that may require training, policy clarification, process](#)

~~improvements, or other follow-up. Agency performance is additionally reviewed through an annual on-site and desk audit review. Should an agency fall below the standards set forth by the Department during the audit, the agency will be placed on a monthly Quality Improvement Plan (QIP) that outlines a work plan to remediate any deficiencies found during the audit. The QIP will remain in place until the Department has determined that the agency is at 100% in compliance with the Provider Solicitation and has an ongoing process to monitor adherence to the standards set forth by the Department. The State performs an annual audit of each agency. SPA liaisons at DHMH engage in ongoing monitoring of compliance, and identification of non-compliance to the provider Solicitation results in CAPs.~~

ii. Take(s) corrective action if there is a failure to comply.

~~The web-based LTSS system, LTSS Maryland, contains data related to service provision, including dates of services, activities performed, and billing. The contract/agreement monitor will review utilization reports to monitor timeliness and compliance. The State will require a CAP corrective action plan for a provider that fails to meet contractual/provider agreement requirements. In the event the providers fail to~~

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~~meet the contractual requirements under the CAP, the State will take action based on procurement rules appropriate action as needed. The Department may terminate the Agreement at any time by notifying the provider in writing. The provider will submit a transition plan that clearly describes how applicants/enrollees will be assisted regarding the selection of a new provider, transition of files and other data in a Health Insurance Portability and Accountability Act of 1996 (HIPAA)-compliant manner and the reason for~~

~~For the termination of a Supports Planning Agency, letters are sent to each participant and they are contacted by phone to notify them of the change in provider status. Participants are afforded the opportunity to choose a new Supports Planning Agency, or are assigned one automatically if they do not choose.~~

~~For termination. For the change in providers of transition funds, the State provided public notice to stakeholders and Supports Planning Agencies.~~

B. Coordination and Continuity of Care Standards

Describe how the State assures that coordination and continuity of care is not negatively impacted by the selective contracting program.

The selective contracting program assures coordination and continuity of care by holding the selected case management entities to the qualifications and performance standards outlined in the solicitation. Since the competitive solicitation process is not associated with funding it allows the Department to solely focus on selecting entities that have demonstrated a commitment to supporting the coordination and continuity of care standards and goals of the Department while preventing conflicts of interest in their proposal. This selective contracting program improves coordination and continuity of care by limiting the number of agencies increasing the Department's ability to monitor service utilization oversight via reports in LTSSMaryland. The reports allow the Department to monitor the number of units of service budgeted on plans of services versus those utilized by the participant, enrollment time frames, reportable events, and other quality indicators. The selective contracting program also allows the Department to provide regular technical assistance via the monthly Supports Planning call, billing audits, and annual case management agency. ~~will improve quality and oversight by limiting the number~~

~~of providers of the service such that the Department may more closely monitor the provision of services. Monthly oversight of performance via reports in the LTSS tracking system of the number of units of service budgeted on plans of service, utilized by participants, time frames for enrollment, and other quality indicators becomes more manageable with fewer providers. Adjustments are based on actual number of hours per month for FY14. Many waiver participants are eligible for and receiving CFC services. These participants receive the majority of their case management through the CFC program, which had the impact of reducing the waiver case management numbers.~~

Part IV: Program Operations

A. Beneficiary Information

Describe how beneficiaries will get information about the selective contracting program.

Upon application for services, the Department will provide a packet of materials that includes brochures from all eligible case management and supports planning providers available in the applicant's area. Applicants are encouraged to contact case management and supports planning providers prior to selection. The applicant may choose a provider by contacting the Department or the chosen provider directly. This choice will be noted in LTSSMaryland. Applicants and participants who do not choose a provider within 21 days of receipt of the provider information packet will be auto assigned to a provider via LTSSMaryland to assure equal distribution of auto assignments among eligible providers. The applicant or participant will be able to change the auto-assigned provider at any time; however, once a provider is chosen by the participant, the 45-day limitation described above will apply.

~~Upon application, a packet of information will be sent to applicants regarding the available~~

~~providers in their geographic region.~~

~~The packet of information includes brochures provided by each case management provider. Each provider may submit a brochure for the~~

~~informational packet.~~ Applicants from nursing facilities will receive this information through the Money Follows the Person Options Counselors. The AAAs and additional providers identified through the competitive solicitation are also responsible for providing required information to participants/enrollees.

~~Enrollees assigned to a case management provider that is being terminated will be notified by mail and contacted by telephone to notify them of the change in provider status. Prior to termination enrollees will have the opportunity to choose a new case management provider. If the enrollee does not select a new provider one will be automatically assigned to them. In the event of the termination of a Supports Planning Agency, participants assigned to that~~

~~agency will be notified directly. Participants are mailed letters and contacted by phone to notify them of the change in provider status. Participants are afforded the opportunity to choose a new Supports Planning Agency, or are assigned one automatically if they do not choose.~~

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~~For the change in providers of transition funds, the State provided public notice to stakeholders and Supports Planning Agencies.~~

B. Individuals with Special Needs.

___ The State has special processes in place for persons with special needs
(Please provide detail).

Section B – Waiver Cost-Effectiveness & Efficiency

Disclaimer – The text highlighted in yellow is still being finalized and will be provided during a subsequent public comment period.

Efficient and economic provision of covered care and services:

1. Provide a description of the State’s efficient and economic provision of covered care and services.

The State estimates that applicants and participants will receive **3 hours** per month of case management which equals ~~\$213192.46~~ per month at the rate of ~~\$17.75~~**\$16.04** per 15 minute unit.

The pre-waiver PMPM cost has been projected to be \$~~261.80~~~~230.28~~, based on historical PMPM costs, which were paid at a flat administrative amount per participant then adjusted for the standard 2.5% annual rate increase. These projections reflect reduced utilization of waiver case management services as many waiver participants receive the service through the Community First Choice state plan program. The state share is made up of combined local and state funds.

2. Project the waiver expenditures for the upcoming waiver period.

Year 1 from: ~~1/1/2021~~~~6~~ to 6/30/20~~22~~~~17~~

Trend rate from current expenditures (or historical figures): ~~N/A~~ 3 %

Projected pre-waiver cost \$ ~~8,310,760~~ 12,933,371.95

Projected Waiver cost \$ 6,945,850

Difference: \$ 1,364,910

Year 2 from: 7/1/20~~22~~~~17~~ to 6/30/20~~23~~~~18~~

Trend rate from current expenditures (or historical figures): ~~2.53~~ %

Projected pre-waiver cost \$ ~~12,618,297~~ 17,936,569.17

Projected Waiver cost \$ 10,636,568

Difference: \$ 1,981,729

Year 3 (if applicable) from: 7/1/20~~24~~~~18~~ to 6/30/20~~25~~~~19~~

~~15~~

Trend rate from current expenditures (or historical figures): ~~2.53~~ %

Projected pre-waiver cost \$ ~~14,368,965~~ 18,661,312.70

Projected Waiver cost \$ 12,216,278

Difference: \$ 2,152,687

Year 4 (if applicable) from: 7/1/20~~25~~~~19~~ to 6/30/20~~26~~~~20~~

Trend rate from current expenditures (or historical figures): ~~2.53~~ %

Projected pre-waiver cost \$ ~~16,362,521~~ 19,413,397.93

Projected Waiver cost \$ 14,030,602

Difference: \$ 2,331,919

Year 5 (if applicable) from: 7/1/20~~2620~~ to 6/30/20~~2721~~

Trend rate from current expenditures (or historical figures): ~~2.53~~ %

Projected pre-waiver cost \$ ~~19,420,100~~ 20,193,813.09

Projected Waiver cost \$ 16,795,395

Difference: \$ 2,624,705